PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, May 28, 2002, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard Koh, (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Maureen Pompeo, Mr. Benjamin Rubin, Ms. Janet Slemenda, Dr. Thomas Sterne. Ms. Shane Kearney Masaschi absent (one vacancy). Also in attendance was Attorney Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A 1/2.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Sally Fogerty, Assistant Commissioner, Bureau of Family and Community Health; Ms. Rebecca Goldstein, Policy Analyst, Division of Maternal, Child and Family Health, Bureau of Family and Community Health; Dr. Judith Weiss, Co-Director, Maternal Mortality and Morbidity Study; Mr. Howard Wensley, Director, Division of Community Sanitation; Ms. Karen Granoff, Director, Office of Patient Protection; Dr. Paul Dreyer, Director, Division of Health Care Quality; Ms. Joyce James, Director, Ms. Holly Phelps, Analyst, Ms. Joan Gorga, Analyst, and Mr. Jere Page, Senior Analyst, Determination of Need Program; and Deputy General Counsels: Carol Balulescu, Edward Sullivan, and Carl Rosenfield.

REQUEST APPROVAL OF BYLAWS OF LEMUEL SHATTUCK HOSPITAL:

The ByLaws of Lemuel Shattuck Hospital, memorandum of May 17, 2002, were presented to Council for approval. After consideration, upon motion made and duly seconded, it was voted (unanimously): That, the ByLaws of Lemuel Shattuck Hospital, memorandum of May 17, 2002, be approved.

PERSONNEL ACTIONS:

In a letter dated May 2, 2002, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the medical staff of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning May 1, 2002 to May 1, 2004:

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Carmencita Lopez, M.D.	Active Staff Internal Medicine	76374
Stephen Ellen, M.D.	Affiliate Staff Psychiatry	73606
Kelly Clark, M.D.	Affiliate Staff Psychiatry	81665

APPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Martin Kafka, M.D.	Provisional Consultant	56419
Tzvetan Tzvetanov, M.D.	Provisional Affiliate	204641
Nilda Laboy, Psy.D	Provisional Allied	7654

In a letter dated May 8, 2002, Mr. Blake Molleur, Executive Director, Western Massachusetts Hospital, recommended approval of a reappointment to the consultant medical staff of Western Massachusetts Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointment to the consulting medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENT:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Leslie Zide-Selbovitz, DMD	Consultant Medical Staff Dentistry	14059

In a letter dated May 13, 2002, Mr. Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, recommended approval of appointments and a reappointment to the medical staffs and allied health professional staff of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointment to the medical and allied health staff of Lemuel Shattuck Hospital be approved as follows:

APPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Rubeen Israni, MD	Internal Medicine Consultant	211039
Oscar Morales, MD	Psychiatry Consultant	150096
Aram Meuschatz, MD	Internal Medicine Consultant	209769
Jeff Palacios, MD	Psychiatry Consultant	213034
Sidhartha Pani, MD	Nephrology Consultant	202686
Anton Pesok, MD	Internal Medicine Consultant	205091
Issac Pourati, MD	Internal Medicine Consultant	212177
Floyd Atkins, MD	Internal Medicine Active	53806
Shreekant Chopra, M.D.	Nephrology Active	39069
Gregory Clark, MD	Psychiatry Active	47584
Dennis Derman, MD	Hem/Oncology Consultant	71738
Stephen Drewniak, MD	Gastroenterology Active	43997
Inna Goldberg, MD	Radiology Consultant	80298
David Haskell, MD	Psychiatry Active	29493
David MacMillan, MD	Psychiatry Active	76602
Timothy Pace, MD	Psychiatry Active	150244
Maria Warth, MD	Endocrinology Active	53898

ALLIED HEALTH PROFESSIONAL INTIAL APPOINTMENTS:

Bruce Swartz, PsyD	AHP	4345

ALLIED HEALTH PROFESSIONAL REAPPOINTMENT:

Robert Jumped, PhD	AHP	1634

In a letter dated May 10, 2002, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Marianne Fleckner to Administrator XI (Deputy Commissioner). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Marianne Fleckner to Administrator XI , Deputy Commissioner, be approved.

In a letter dated May 10, 2002, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Susan J. Stanewick to Administrator VIII, Assistant Commissioner for Administration. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendations of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Susan J. Stanewick to Assistant Commissioner for Administration be approved.

In a letter dated May 20, 2002, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Walter Nardi to Program Manager Specialist III (Chief Engineer, Power Plant –Lemuel Shattuck Hospital). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Walter Nardi to Program Manager Specialist III (Chief Engineer, Power Plant – Lemuel Shattuck Hospital) be approved.

STAFF PRESENTATION:

"SAFE MOTHERHOOD: PREGNANCY-ASSOCIATED INJURY DEATHS, 1990 – 1999" – PRESENTATION BY REBECCA GOLDSTEIN, POLICY ANALYST, DIVISION OF MATERNAL CHILD AND FAMILY HEALTH, BUREAU OF FAMILY AND COMMUNITY HEALTH AND MS. SALLY FOGERTY, ASSISTANT COMMISSIONER, BUREAU OF FAMILY AND COMMUNITY HEALTH:

Ms. Rebecca Goldstein, Policy Analyst, Division of Maternal, Child and Family Health, Bureau of Family and Community Health, presented data regarding Pregnancy – Associated Injury Deaths. Ms. Goldstein said in part, "…Homicide, most often the result of domestic violence, is the leading cause of death in Massachusetts of women during pregnancy or up to one year following the end of pregnancy…From 1990-1999, 232 women died from any cause while pregnant or during the first year postpartum. That is, for every 100,000 live births, there were 27 pregnancy- associated deaths. Thirty of these 232 deaths were due to homicide with two-thirds (20) of the homicide deaths tied to

known or alleged cases of domestic violence. Massachusetts is one of the safest states in the country to have a baby. The risk of a woman dying during pregnancy or within one year of birth is extremely low in this state."

Among the highlights of Pregnancy-Associated Injury Deaths: Violence, Substance Abuse and Motor Vehicle Collisions, 1990-1999:

- More than one-third of the deaths were injury-related.
- For every 100,000 live births, there were 9 pregnancy-associated deaths caused by injury.
- Most injury-related deaths (73%) occurred between 42 and 363 days postpartum.
- 9 out of 10 homicides occurred between 6 months and one year postpartum.
- Other causes of injury-related deaths were motor vehicle collisions, drug overdose, suicide, and other injuries. The leading cause of medical deaths was cancer.
- No drug overdose deaths occurred during pregnancy, a time when women have greater access to treatment.
- The majority of suicides occurred after the first 6 weeks postpartum.
- Deaths caused by motor vehicle collisions occurred throughout the entire period, with two –thirds occurring after the traditional 6 week postpartum period.
- All injury deaths are considered to be preventable by one or more changes in the health care system related to clinical care, facility infrastructure, public health infrastructure, and/or patient factors.
- Black non-Hispanic women were four times more likely and Hispanic women two times more likely to die of injury causes than white non-Hispanic women.
- Younger women (age15-24) were 3 times more likely to die than older women.
- Low income (less than 225% of federal poverty level) women who had a live birth and a public payer such as MassHealth or Healthy Start, were 7.5 times more likely to die from pregnancy-associated injury as women with a private payer.

The timing of these deaths suggests a prevention strategy that includes not only obstetrical providers, but a variety of providers that have access to pregnant women and mothers of infants throughout the first year postpartum. All strategies should be developed with a respect for the woman's culture, as well as recognition that of the complexity of women's lives.

Strategies for prevention include, but are not limited to the following:
-Screen and rescreen all pregnant women and all mothers of infants for domestic violence, suicide risk, depression and postpartum depression, substance use and seatbelt use.
Educate all women about these issues.
Advise and counsel women at risk.
Document screening results and injuries carefully.
Institute policies and protocols for screening and referral.
Promote a comprehensive response to injury prevention in your community.

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON 105 CMR 450.000: MINIMUM HEALTH AND SANITATION STANDARDS FOR DYS SECURE RESIDENTAL FACILITIES:

Mr. Howard Wensley, Director, Division of Community Sanitation, said in part, "Since the early 1900's the Department of Public Health, pursuant to M.G.L. c. 111, s20, has been authorized to set the health and sanitation standards for secure juvenile detention facilities under the control of the Department of Youth Services. In the past, this authority has included the obligation to inspect such facilities at various intervals. For approximately thirty years, the Department has inspected these facilities pursuant to its regulations promulgated at 105 CMR 450.000 and reported the results back to DYS. Within the last decade, another state agency, the Office of Child Care Services, has also relied exclusively on DPH inspection reports of secure DYS facilities to license these programs. Although 105 CMR 450.000 originally set the requirements for both adult correctional facilities and juvenile facilities, statutory amendments to c.111, s20 in the 1970's and 1980's removed secure DYS facilities from mandatory DPH inspections. In the absence of regulatory authority, the Deparment's Division of Community Sanitation has continued to inspect all secure DYS facilities to ensure that they were adequately maintained. In early 2002, the Department began a review of 105 CMR 450.000 in an effort to update the regulations and check them for legal accuracy. In light of the fact that statutory authority for DPH to inspect secure DYS facilities no longer existed, such references needed to be deleted. At the same time, DYS and DPH wanted to ensure that necessary inspections continued and therefore the agencies are in the process of developing a Memorandum of Understanding that will authorize DPH to continue to inspect secure DYS facilities. Aside from the changes noted below, no significant substantive changes were made to the regulations other than eliminating the procedures for inspections and reporting. Some language has been altered in order to address changes in the scope and to revise some text to improve the clarity of the text. These changes include changing "detainee" or "inmate" to "resident", and changing "detention facility" to "DYS secure residential facility."

NO VOTE, INFORMATIONAL ONLY

REGULATIONS:

REQUEST APPROVAL OF AMENDMENTS TO 105 CMR 128.000: HEALTH INSURANCE CONSUMER PROTECTION REGULATION:

Attorney Carol Balulescu, Deputy General Counsel, introduced the regulations. She said in part, "…The Office of Patient Protection is proposing amendments to its regulations to correct typographical errors, to add or clarify definitions and clarify or expand requirements for carriers in a variety of areas. The first was to clarify that the thirty day grievance resolution period does not begin to run until an insured has notified the plan

that he or she is not satisfied with the response to an inquiry. The second was to clarify requirements for written waivers of time periods. We did have a public hearing on April 12th, and accepted written comments, as well. These first two proposals did not generate any comments and we are proposing that the changes be made as we had originally proposed. We also attempted to clarify carrier's responsibilities regarding the provision of medical records to the external review agency. This generated a number of comments from carriers. We had tried to to clarify responsibilities in two areas where information was requested from participating providers and where information was requested from other providers who were not under contract with the carriers."

Attorney Balulescu continued, "What we heard from the carriers is that, in reality, there is not much difference in obtaining information and, in response to their concerns, we have changed the proposal to create a good faith standard so that it is clear that carriers are responsible for obtaining any and all records requested by the external review agencies and we have set up a good faith standard so that carriers who are attempting, in good faith, to obtain medical records as requested will not be penalized if it is the provider who fails to respond to the request. We had also tried to clarify that where an insured is asking for continuation of services during an external appeal, that in order to make such a request, the request had to be made within two business days of receiving the final adverse determination from an insurance carrier…We had heard from consumers that forty-eight hours could unfairly penalize insureds who received adverse determinations on a Friday or over a holiday weekend. In response to the comments, we are proposing that the request for continuation of services has to be made now within two business days of receiving the final adverse determination, and this well not unfairly penalize a consumer who receives an adverse determination of a Friday, or over a long holiday period…"

"We had also tried to clarify the opportunity for standing referrals. The law, as it was written, stated that an insured has an opportunity to receive a standing referral for specialty care from a primary care physician. We had seen some problems for insureds obtaining standing referrals for mental health services, and we had attempted to set up a process that distinguished between services that required referrals from primary care physicians and those services that were handled through some other type of arrangement in a health plan. In doing so, we had set forth a requirement not for standing referrals, but standing authorizations. And the comments we heard from the carriers was that the standing authorization went beyond the scope of the original statute, that an authorization is different from a referral. And that, in attempting to do so again, that we had exceeded the authority of the statute. In reviewing the testimony and reviewing the changes that we had proposed, what we did was just took a step back and simplified the language to make it clear that standing referrals apply to mental health services as well as any other specialty services, and it really does not matter how the health plan issues referrals for mental health care."

"Two other proposed changes generated very little comment. One was to require a carrier to designate an individual with authority to approve claims that are the subject of appeals to the Office of Patient Protection and we had proposed to change the language

regarding termination without cause to be identical to the language contained in the Division of Insurance regulation. And those changes are as originally proposed with some very minor revisions to the one on the appointment or the designation of an individual with authority to approve claims. …We would propose to go ahead with these amendments and file them with the Secretary of State for promulgation on June 21st of this year, with your approval."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve **Amendments to 105 CMR 128.000: Health Insurance Consumer Protection Regulation**; that a copy be forwarded to the Secretary of the Commonwealth for promulgation; and that a copy of the regulations be attached to and made a part of this record as **Exhibit Number 14,738.**

REQUEST PROMULGATION OF EMERGENCY AMENDMENT TO 105 CMR 130.000: HOSPITAL LICENSURE – INTERIM TRAUMA CENTER DESIGNATION:

Dr. Paul Dreyer, Director, Division of Health Care Quality, said in part, "The purpose of this memorandum is to request the Public Health Council's emergency promulgation of an amendment to the Department's hospital licensure regulations. The proposed amendment addresses the conditions under which hospitals may hold themselves out to the public as trauma centers. In the absence of this emergency regulation, provisions in "EMS 2000" would prevent any hospital from holding itself out to the public or advertising itself as a trauma center after June 24, 2002. The Council originally promulgated this regulation on an emergency basis at its March meeting, and the regulation will expire prior to the June PHC meeting if not re-promulgated. On September 25, 2000, EMS 2000took effect. Among its many new programs, EMS 2000 required the Department to develop and implement a statewide trauma care system. Over a year ago, the Department convened a State Trauma Committee to develop recommendations for such a system. The Committee, chiefly through its four working subcommittees, has sent final recommendations to the Massachusetts Emergency Medical Care Advisory Board (EMCAB) for its review. After EMCAB review, the Department will receive the recommendations and begin its process of evaluation and regulatory development. However, "EMS 2000" also includes a requirement that after 18 months from its effective date, which was March 26, 2002, a health care facility cannot use the terms "trauma facility," "trauma center" or similar terminology in its signs or advertisements, unless it has been designated a trauma center by the Department. In order to maintain the current system of trauma care pending full implementation of a new trauma system, the Council promulgated an interim regulation that allowed hospitals to continue to call themselves trauma centers. The finalization of the Trauma Committee's recommendations and the review by EMCAB will not be completed prior to the expiration of the 90-day period during which the emergency regulations will be effective. The re-adoption of the regulation on an emergency basis will allow sufficient time for the completion of the process while maintaining an interim system for trauma center designation. The proposed regulation allows a hospital to continue to use the terms "trauma facility," "trauma center or similar terminology in its signs or advertisements if it

meets one of two tests: 1) It has verification from the American College of Surgeons as a Level I, II or III trauma center; or, 2) It has been recognized in a regional point of entry plan as a recipient of trauma patients. Because virtually all hospitals that hold themselves out as providing trauma care meet one of these two tests, this emergency regulation will maintain the current system pending final approval the new trauma system currently under development."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to **approve the Request for Promulgation of Emergency Amendment to 105 CMR 130.000: Hospital Licensure – Interim Trauma Center Designation**; that a copy be forwarded to the Secretary of the Commonwealth for promulgation; and that a copy of the regulations be attached to and made a part of this record as **Exhibit Number 14,739.**

DETERMINATION OF NEED PROGRAM:

CATEGORY 2 APPLICATIONS:

PROJECT APPLICATION NO. 4-3A05 OF NEWTON WELLESLEY TO PROVIDE POSITRON EMISSION TOMOGRAPHY (PET) SERVICES THROUGH ACQUISITION OF A MOBILE PET BODY SCANNER TO BE LOCATED ON AN EXISTING PAD NEXT TO THE NUCLEAR MEDICINE DIVISION OF THE RADIOLOGY DEPARTMENT:

Ms. Holly Phelps, Analyst, Determination of Need Program, said in part, "…Newton Wellesley Hospital is proposing to establish a PET service by purchasing a mobile PET scanner that will be situated on a pad near the Nuclear Medicine section of the Radiology Department and the recommended maximum capital expenditure for the project is two million, fourteen thousand dollars, and it will be funded with one hundred percent equity from the hospital. The project was reviewed against the standards in our PET guidelines and was found to meet the requirements and, in particular, the project was found to demonstrate meeting and surpassing the projected number of PET scans. That minimum is twelve fifty and we expect this project to do in excess of nineteen hundred scans per year. For its Community Health Initiative, Newton-Wellesley Hospital is proposing to contribute a hundred thousand dollars over five years Seventy thousand dollars will go to a small grants program that will be administered by the Community Health Network Agency, and the other thirty thousand dollars will go to the City of Newton Department of Health and its Pediatric Safety Net Program that identifies uninsured kids and kids that are in need of immunization and connects them with primary care physicians and immunizations. There was a Ten Taxpayer Group in the project, the Mark Taylor Ten Taxpayer Group, but the Ten Taxpayer Group submitted no comments. Staff is recommending approval of this project with conditions."

PROJECT APPLICATION NO. 4-3A06 OF MASSACHUSETTS GENERAL HOSPITAL TO PROVIDE POSITRON EMISSION TOMOGRAPHY (PET) SERVICES THROUGH ACQUISITION OF TWO COMBINATION PET/CT (COMPUTERIZED AXIAL TOMOGRAPHY) SCANNERS AND ASSOCIATED RENOVATION FOR LOCATION OF ONE PET/CT SCANNER IN THE DIVISION OF NUCLEAR MEDICINE, DEPARTMENT OF RADIOLOGY, AND THE OTHER PET/CT SCANNER IN THE PROTON THERAPY CENTER WITH SERVICE TO BE PROVIDED BY THE DEPARTMENT OF RADIOLOGY:

Ms. Joan Gorga, Program Analyst, Determination of Need Program, said in part, "Massachusetts General, a tertiary care hospital located in Boston, is before you today seeking approval to provide PET scanning through the purchase of two combination PET/CT body scanners. Mass General has opted to acquire a combined Positron Emission Tomography Computerized Axial Tomography (PET/CT) scanner, which has recently received pre-market approval by the Food and Drug Administration for commercial use. The combination machine uses the capabilities of both diagnostic tools. The CT locates masses in the body, but cannot determine if they are cancerous, while the PET can detect tiny cancers, but cannot exactly pinpoint their location. MGH has been in the vanguard of the development of PET technology and has been providing the service for almost forty years, well before it was regulated by the Determination of Need Program. MGH presently operates two PET scanners approved in 1994 as part of a previously approved project. One of the two proposed new scanners will be located in the Division of Nuclear Medicine and the other in the Proton Therapy Center. The application was reviewed against the factors of the Determination of Need Guidelines for PET. The recommended MCE of the Mass General project is four million, seven hundred thousand dollars, which will be funded through an equity contribution from the applicant's unrestricted funds. The applicant has projected that the scanner will exceed the minimum annual volume of two thousand, five hundred for two scanners, as required in the guidelines. Staff found that, in response to the Community Health Initiatives, Mass General has offered Community Initiatives of two hundred and fifty thousand dollars over a five year period for support of scholarships and academic support for the training of radiology technicians in the local community, for support of the Youth Care Program, a program located in Charlestown for children with emotional and social disabilities, and for mini grants to further the priorities of the Area Community Network. One Ten Taxpayer Group registered in connection with the application, but did not submit comments. In conclusion, staff recommends approval of the application, Project No. 4-3A06, with the conditions as indicated in the staff summary, which have been agreed to by the applicant."

PROJECT APPLICATION NO. 4-3A07 OF DANA FARBER CANCER INSTITUTE TO PROVIDE POSITRON EMISSION TOMOGRAPHY (PET) SERVICES THROUGH ACQUISITION OF A COMBINATION PET/CT (COMPUTERIZED AXIAL TOMOGRPHY) SCANNER AND ASSOCIATED RENOVATION FOR LOCATION OF THE PET/CT SCANNER IN THE DEPARTMENT OF RADIOLOGY:

Mr. Jere Page, Senior Analyst, Determination of Need Program, said in part, "Dana Farber is doing the same thing that MGH is talking about. It is expanding its existing PET service by adding a combination PET/CT scanner and the associated renovation to accommodate the new unit within the Institute's Radiology Department. The recommended MCE is 2.6 million dollars, which will be funded by a one hundred percent equity contribution. The project was reviewed against the review factors in the DON guidelines and staff found that the proposed PET/CT service will exceed minimum volume requirements, as well as provide more accessible PET/CT services to Massachusetts residents. Staff also notes that, in response to the Community Initiatives requirements, Dana Farber has agreed to provide a total of one hundred and thirty thousand dollars over a four year period to fund several cancer screening and prevention programs through Boston area community-based health and wellness organizations, as well as through the Dana Farber Mobile Mammography Van. There is a taxpayer group on this one, as there is on the other two. No comments were submitted. In conclusion, we recommend approval with conditions."

After consideration, upon motion made and duly seconded, it was voted unanimously to approve all three applications for PET scanning:

Project Application No.4-3A05 of Newton-Wellesley Hospital to provide Positron Emission Tomography (PET) services through acquisition of a mobile PET body Scanner to be located on an existing pad next to the Nuclear Medicine Division of the Radiology Department;

Project Application No. 4-3A06 of Massachusetts General Hospital to provide Positron Emission Tomography (PET) services through acquisition of two combination PET/CT (Computerized Axial Tomography) scanners and associated renovation for location of one PET/CT scanner in the Division of Nuclear Medicine, Department of Radiology, and the other PET/CT scanner in the Proton Therapy Center with service to be provided by the Department of Radiology; and

Project Application No. 4-3A07 of Dana Farber Cancer Institute to provide Positron Emission Tomography (PET) services through acquisition of a combination PET/CT(Computerized Axial Tomography) scanner and associated renovation for location of the PET/CT scanner in the Department of Radiology.

Summaries are attached to and made a part of this record as **Exhibit No.14,740.**

This Determination of Need is subject to the following conditions:

Newton-Wellesley Hospital , Project No. 4-3A05:

1. The Applicant shall accept the maximum capital expenditure of $2,014,000 (August 2001 dollars) as the final cost figure, except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. NWH shall contribute 100% in equity toward the final approved MCE.

3. The Applicant shall not consider ability to pay or insurance status in selecting or scheduling patients for PET services.

4. The Applicant will provide $100,000 (August 2001) over a five year period ($20,000 annually), as follows:

a) $70, 000 over a five year period ($14,000 annually) for a mini-grant (s) program for prevention services or programs. The funds shall be awarded to providers through an RFP process to be developed, administered and evaluated by Community Health Network Agency (CHNA 18);

b) $30,000 over a five year period ($6,000 annually) for grants to the Newton Department of Health for the Pediatric Safety Net program, a service which provides outreach and care to children through the school system who are uninsured and/or require immunizations and primary care.

Massachusetts General Hospital, Project No. 4-3A06:

1. The Applicant shall accept the maximum capital expenditure of $4,700,000 (August 2001 dollars) as the final cost figure, except for those increases allowed pursuant to 105CMR 100.751 and 752.

2. The Applicant shall contribute 100% in equity toward the final approved MCE.

3. The Applicant shall not consider ability to pay or insurance status in selecting or scheduling patients for PET services.

4. The Applicant will provide $250,000 over a five-year period for support of scholarships and academic support for the training of radiology technicians in the local community, for support of the YouthCare program and for mini-grants to further the priorities of the Harbor Area Community Health Network Area (CHNA). Funding for these initiatives will begin upon implementation. The specific service initiatives and associated funding are described below.

Support for Radiology Technician Training: $10,000 each year for 5 years for scholarship grants to local residents, particularly minority residents of the local

communities, to become radiology technicians through enrollment in accredited programs such as the one offered at Bunker Hill Community College. The project will target residents of the communities within the Harbor Area CHNA particularly Chelsea and Revere and will work cooperatively with the Harbor Area CHNA to develop recruit strategies and gain input on the development of this program.

YouthCare: $10,000 each year for 5 years for the operating budget of YouthCare to support the expansion of this program located in Charlestown for children with emotional and social disabilities. The program offers therapeutic summer camp and after school programs as well as training and support for parents.

CHNA MINI GRANTS: $10,000 each year for 5 years for a mini-grants program for initiatives to carry out the priorities of the Harbor Area CHNA. The funds shall be awarded to providers through an RFP process to be developed, administered and evaluated by the Alliance for Community Health (CHNA 19) and a representative of MGH shall be included in the grant making process.

Dana Farber Cancer Institute, Project No. 4-3A07:

1. Dana Farber Cancer Institute shall accept the approved maximum capital expenditure of $2,628,750 (August 2001 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. Dana Farber Cancer Institute shall contribute 100% in equity ($2,628,750 in August 2001 dollars) toward the final approved MCE.

3. Dana Farber Cancer Institute shall not consider ability to pay or insurance status in selecting or scheduling patients for PET services.

4. Dana Farber Cancer Institute shall provide a total of $130,000 (August 2001 dollars) over four years at $32,500 per year to fund community health service initiatives involving the two prevention programs described below:

1) $9,000 per year over four years for a total of $36,000 will be provided to fund three (3) mini-grants, which will be $3,000 each, distributed annually to neighborhood groups selected by the Alliance Coalition for the City of Boston (Community Health network Area #19) for the provision of certain prevention programs. Dana Farber and representatives from the Alliance Coalition's Operation Committee will determine whether the funds provided will be used for cancer prevention, skin cancer prevention or other programs yet to be determined by the specific neighborhood groups. Dana Farber will provide an additional $1,000 per year over four years for a total of $4,000 to support the activities of the Alliance, including the development of newsletters, support staff, materials and mailings.

2) $22,500 per year over four years for a total of $90,000 to fund breast cancer and cervical cancer screening services through Dana Farber's mobile mammography van,

as well as the Breast and Cervical Screening Collaborative (BCSC), which includes Dana Farber, Partners Healthcare System, and seventeen community health centers in and around Greater Boston. The breast cancer screening will be provided for uninsured and underinsured women, age 40 and over, while the cervical cancer screening will involve women 18 and over. Dana Farber and the BCSC will work to locate and encourage women to come in for screening, as well as ensure timely and appropriate follow-up care, and facilitate access to diagnostic and treatment services. Dana Farber's funding will be used mainly to support the health promotion and outreach activities of the project coordinators and outreach workers at each of the health centers. Funding for this initiative will begin upon project implementation, and notification to the Department's Office of Healthy Communities.

ALTERNATE PROCESS FOR TRANSFER OF OWNERSHIP APPLICATION:

PROJECT APPLICATION NO. 4-3A26 OF BRAINTREE HOSPITAL, LLC, C/O COMMONWEALTH COMMUNITIES, INC. – REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF OLYMPUS SPECIALITY HOSPITAL – BRAINTREE AND ITS SATELLITES LOCATED AT STOUGHTON AND NATICK, RESULTING FROM ACQUISITION OF THE HOSPITAL'S ASSETS BY BRAINTREE HOSPITAL, LLC AS PART OF A CHAPTER 11 REORGANIZATION PLAN:

Ms. Joyce James, Director, Determination of Need Program, said in part, "…At the April 23, 2000 meeting, when the Council considered the transfer of ownership of this hospital to another applicant, the Deputy General Counsel indicated that the hospital might be presented to you again because the bankruptcy court in Wilmington, Delaware had not yet decided on a bidder to acquire the assets of the hospital. Following the Public Health Council Meeting on April 23, the court held an auction on May 16, 2002 and approved the highest bidder for the hospital assets. That highest bidder is now the present applicant of this transfer of ownership presented to you today. We are recommending approval of the application because we find that it satisfies the process requirements and the standards of review under the Determination of Need regulations for the alternate process for transfer of ownership of hospitals. The applicant requested a public hearing which was held here at the Deparment of Public Health on May 17th. Three persons attended the hearing. The applicant testified, asking that the Department act favorably on the application so that the services could remain in the area. At that hearing, the applicant also submitted letters of support for the project. Residents within the hospital service area submitted comments on the application. These comments claimed that the application did not satisfy the process requirements of the alternate process and that there were also concerns about beds out of service and whether or not they should be approved as part of this transfer of ownership. The comments indicated that, in the event the application was approved, it should be approved with the condition that the project be approved in part and the thirty-five beds that are now out of service at the Braintree site should not be part of this transfer of ownership and if those beds were restored, they should file a Determination of Need application because it would constitute a substantial change in service. As indicated in the staff summary, in our response to these

comments, we find no basis that the application did not meet the process requirements of the alternate process. We also indicated that beds out of service are part of the licensed capacity of a hospital, and should be part of the beds that were transferred as approval of this transfer of ownership. In conclusion, we find no basis in the comment submitted to warrant that this application not be supported as submitted."

After consideration, upon motion made and duly seconded, it was voted, unanimously, to **approve Project Application No. 4-3A26 of Braintree Hospital, LLC, c/o Commonwealth Communities, Inc. – Request for transfer of ownership and original licensure of Olympus Specialty Hospital – Braintree and its satellites located at Stoughton and Natick, resulting from acquisition of the hospital's assets by Braintree Hospital, LLC as part of a Chapter 11 reorganization plan;** that the summary is attached and made part of this record as **Exibit No. 14,741.**

PROJECT APPLICATION NO. 4-3A27 OF DEACONESS-WALTHAM HOSPITAL, INC. – REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF DEACONESS-WALTHAM HOSPITAL, RESULTING FROM THE RESIGNATION OF THE EXISTING BOARD OF TRUSTEES AND CAREGROUP, INC. ITS SOLE CORPORATE MEMBER, AS DESCRIBED IN THE MEMORANDUM OF UNDERSTANDING. THE NEW BOARD OF TRUSTEES HAVE BEEN SELECTED BY THE COALITION TO SAVE WALTHAM HOSPITAL, INC.:

Ms. Holly Phelps, Analyst, Determination of Need Program, said, "Deaconess-Waltham Hospital is proposing a change of ownership and original licensure, and this is coming about as a result of the resignation of the existing Board of Trustees and the resignation of CareGroup as the sole member of the Deaconess-Waltham Hospital Corporation. CareGroup announced its intention to close Deaconess-Waltham Hospital on April 11th. There was a meeting at the high school in Waltham on February 11, 2002. Thirteen hundred individuals attended. The meeting was co-chaired by the Commissioner. Since that time, there had been tremendous effort on the part of the Coalition to Save Waltham Hospital…it is a remarkable consumer group that got together.…The attitude surrounding the proposal is celebratory and universally positive…There was a hearing on the project . All the comments were positive and in support of the proposal. There were some written comments, submitted by a member of the City Council, having to do with zoning and real estate development, but these were not relevant to our DoN consideration of the project. Staff found that the proposal met all the requirements of our alternative process for transfer of ownership of a hospital and in particular that the hospital will maintain its level of free care at 1.94 percent. After the proposed transfer of ownership, the Board will be appointed by the consumer group and the name of Waltham Hospital will be changed and the intention is to operate the hospital as a non-profit community hospital, independent of a health care system. Staff is recommending approval of this proposal with conditions.

Attorney Lawrence B. Litwak, of Brown, Rudnick, Berlack, Israels, LLP, Coalition to Save Waltham Hospital, said in part, "I am here today representing the Coalition to Save

Waltham Hospital. We are here to request your approval of this transfer of control from CareGroup to a group of community –based trustees.A great deal of work has gone into getting us to the point we are at today. There has been a very serious analysis and review of the hospital's operations. Independent expert consultants and management have been retained to assess the hospital's viability and to develop a turnaround plan. During the past three months, the Coalition has been able to work with the private developer, to come up with a plan to save the hospital. We have had extensive negotiations with CareGroup to work out the business terms relating to the transfer of control and a variety of common issues. In addition, the medical staff and management have been able to work with the New England Medical Center to develop plans for a clinical affiliation that will increase utilization of Waltham Hospital and will strengthen and benefit both the hospital and New England Medical Center. A lot of thought has gone into deciding the composition of the new Board of Trustees, and who should fill these positions. The Coalition has been able to attract a group of individuals with diverse experience, talent, and backgrounds, who represent a variety of community interests. The new Board will have up to twenty trustees…The seventeen trustees already designated include community leaders with prominent business experience, and individuals with diverse experience, talent and backgrounds, who represent a variety of community interests…"

Ms. Dawn Gideon, Coalition to Save Waltham Hospital, said in part, "…I am here to comment on Waltham Hospital's future. I am proud to say that we have a plan that will result in our having nearly 9.5 million dollars in cash on the day of transfer of control. It outlines fourteen million dollars in improvements through expense reduction and revenue enhancements, including the affiliation with New England Medical Center, an affiliation that is actively being pursued by the management team and the medical staff of that organization and with our hospital on a daily basis. That fourteen million dollar improvement will result in a sustained cash profitability, positive cash flow by April of 2004, and an operating profit for this organization in its second full year of operation. This plan and approval of the transfer of control will allow the Waltham Hospital to remain in the community, to provide inpatient/outpatient emergency services to medical, surgical, and psychiatric patients, the insured and uninsured in Waltham and immediately surrounding communities."

Dr. Thomas O'Donnell, CEO, New England Medical Center, said in part, "…Our role is to enhance clinical activity of the hospital, both inpatient and outpatient. Inpatient through transfer of adult psychiatric beds at New England Medical Center to an existing psychiatric clinical activity there, which will allow it to grow further…In addition, we have our vascular surgeon who will be spending time out there. Waltham has a very high proportion of Medicare patients and has a vital need to deliver vascular care in the community close to where the patient lives. Our cardiologists will be working with the congestive heart failure program, which is the most common cause of admission to hospitals, and finally working with pulmonary care. As far as ambulatory activities, our physicians have met with the physicians at Waltham Hospital. They will be taking office space in the adjoining office building to provide specialty care, not to take cases away from the physicians at Waltham, but to amplify their capabilities…Finally, we hope to

participate in a surgi-center, which will allow ambulatory surgery to be performed close to where the patients live, where it is very appropriate to deliver this…"

After consideration, upon motion made and duly seconded, it was voted unanimously: Chairman Koh, M.D., Ms. Cudmore, Mr. George Jr., Ms. Pompeo, Mr. Rubin, Ms. Slemenda in favor; Dr. Sterne recused; Ms.Kearney Masaschi absent; one vacancy, that **Project Application No. 4-3A27 of Deaconess-Waltham Hospital, Inc. – Request for transfer of ownership and original licensure of Deaconess-Waltham Hospital, resulting from the resignation of the existing Board of Trustees and Care Group, Inc., its sole corporate member, as described in the Memorandum of Understanding. The new Board of Trustees have been selected by the Coalition to Save Waltham Hospital, Inc**.; that a summary be attached and made a part of this record as **Exhibit Number 14,742.**

The meeting adjourned at 11:45 a.m.

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Howard K. Koh, M.D., Chairman
Public Health Council

LMH/SB